Membership Application
WV I/DD Waiver Quality Improvement Advisory Council

Type of representation on the council (check ✓)

☐ Current or former program Member/Legal Representative/Family Member

☐ Stakeholder (family, community member, advocate of persons with ID)

☐ I/DD Waiver Provider

Name	
Physical Address	
Email Address	
Telephone Number	
Date Submitted	

Please provide a brief description of your experience in the field of disabilities and the I/DD Waiver program. Why do you want to serve on the QIA Council? (Use back of page if necessary)

☐ (Check if applicable) **I certify that I am willing and able to attend and participate in person in at least quarterly meetings of the QIA Council.**

Applicant Signature:

_____

Submit Membership Application via email to wviddwaiver@apshealthcare.com or fax to 866-521-6882.